



CHANGE IN STATUS/BENEFICIARY/NAME

Group #	Division	Class	Certificate #	Name of Employer	Employee Surname
20320				Central Ontario Standardbred Association	
					Employee First Name

You and your dependents must be insured under your Provincial Benefit Plan in order to participate in RWAM's group insurance plan. In order to process your request, this form must be dated and signed.

STATUS CHANGE REQUEST Single to Family Single to Couple Couple to Family Other

* If you and/or your dependents are electing to waive health and/or dental coverage, please complete the opt-out section below.

<input type="checkbox"/> Marriage (date of marriage) _____ complete dependent information below	<input type="checkbox"/> Separation (date of separation) _____ Are children still to be covered under your policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is spouse still to be covered under your policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you legally obligated to provide these benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide copy of legal agreement or court order
<input type="checkbox"/> Birth of Child - complete dependent information below	<input type="checkbox"/> Divorce (date of divorce) _____ Are children still to be covered under your policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is spouse still to be covered under your policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you legally obligated to provide these benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide copy of legal agreement or court order
<input type="checkbox"/> Common-law spouse (date co-habitation began) _____ complete dependent information below	<input type="checkbox"/> Death of Dependent (date of death) _____ Relationship to Employee _____
<input type="checkbox"/> Children of Common-law Spouse List all eligible dependents below. Do the children reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ELIGIBLE DEPENDENT INFORMATION

Name (state surname if different than yours)	Date of Birth (yy/mm/dd)	Name (state surname if different than yours)	Relationship to Employee	Date of Birth (yy/mm/dd)
Spouse _____	_____	Children* _____	_____	_____
Students aged 21 or over and under 25 (or as specified in your plan) are only eligible if they submit confirmation of full-time registration.				
*Children of common-law spouses must reside with the employee to be eligible.				

WAIVE/OPT-OUT OF EXTENDED HEALTH CARE AND/OR DENTAL BENEFITS

REQUESTED CHANGE: Family to Single Family to Couple Family/Single to Exempt

I certify that I have been given the opportunity to participate in my employer's insurance plan. Comparable coverage is currently provided to me and/or my dependents under another group plan. Because of these existing benefits, I am declining coverage as indicated: Check option A or B, but not both.

A – Employee and Dependent(s) Health Dental **B – Dependent(s) only** Health Dental

My spouse is employed by _____ Insured by (carrier) _____

Spousal Coverage commenced on (date) _____

I understand that if I cease to be covered under my spouse's plan and I wish to participate in the benefits hereby declined, I must complete the Previously Waived Benefits section of this form within 31 days of loss of coverage. If I do not apply within 31 days, I must submit evidence of insurability satisfactory to the Insurance Company which may be at my own expense. Dental coverage, if applicable, will be limited to \$250 per individual for the first year of coverage.

EMPLOYEE NAME CHANGE

New Legal Surname _____ First Name _____

BENEFICIARY CHANGE - original signed form must be submitted

I revoke all prior beneficiary designations under this certificate. I hereby designate the following person(s) to receive all group life insurance benefits payable on my death. If more than 1 person is named, proceeds are to be shared equally, unless otherwise stated below. A separate Beneficiary Designation/Change form is required to appoint contingent beneficiaries.

Beneficiary(ies) *

Name(s) (first, middle initial, last)	Relationship to Employee	% Share (must = 100%)
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

Trustee * If a beneficiary is under age 18: Consider naming a Trustee as benefits cannot be paid to a minor. Benefits will be paid to the named Trustee (regardless of beneficiary age) unless you change the designation to remove the Trustee.

Trustee Name (first, middle initial, last)	As Trustee for (beneficiary name)	Relationship to Beneficiary
_____	_____	_____
_____	_____	_____

Witness must be over 18 and not be a beneficiary

Witness (Signature) **X** _____ Date _____

Authorization: I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by me.

Employee's Signature **X** _____ Date _____